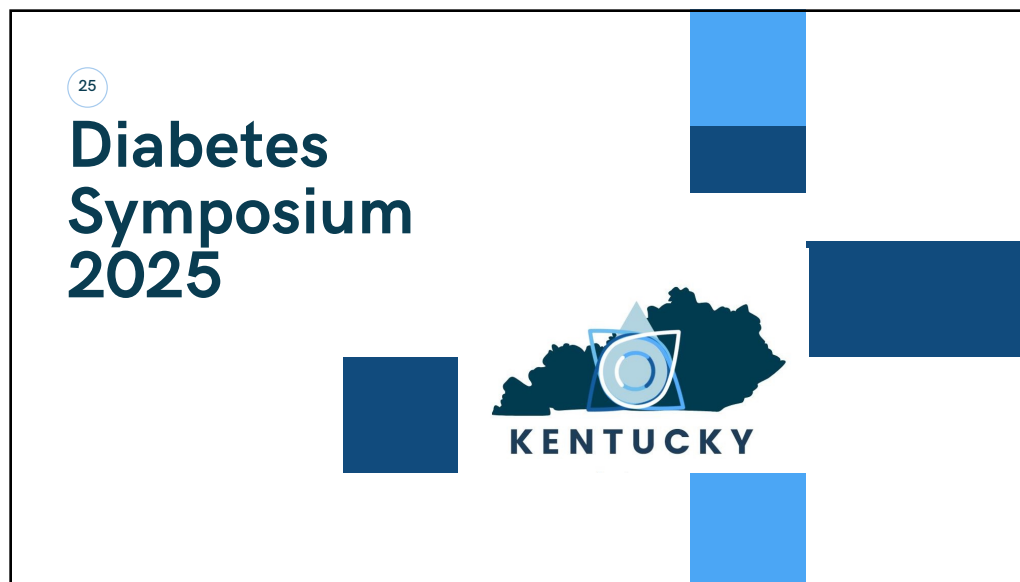




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2

Disclosure to Participants



- Notice of Requirements For Successful Completion
 - Please refer to learning goals and objectives
 - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
- Conflict of Interest (COI) and Financial Relationship Disclosures:
 - None to disclose
- Non-Endorsement of Products:
 - Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity
- Off-Label Use:
 - Participants will be notified by speakers to any product used for a purpose other than for which it was approved by the Food and Drug Administration.



3

Learning Objectives

After completing this activity, the participant should be able to:

- Understand the latest advancements in diabetes medications
- Review current pharmacotherapy and factors that drive selection
- Apply clinical pearls to improve diabetes management
- Navigate cost barriers to ensure accessible treatment



2/2

4

POLL

Which of the following advancements in diabetes medications can we expect to see in 2026?



- a) Once weekly long-acting (basal) insulin
- b) Indication for tirzepatide in type 1 diabetes
- c) Once monthly GLP1 agonist
- d) Glucose responsive insulin
- e) A drug that cures type 1 diabetes

5

Introduction



- ~38 million Americans with diabetes
- Rising type 2 diabetes prevalence (T2D)
- Staying updated = better outcomes for our patients

What is the biggest challenge in your practice?



- Clinical pharmacist in primary care at academic medical center
- Disease state management in primary care clinics
 - General Family Medicine
 - Timothy Freeman Center for developmental disabilities
- Providing diabetes care for ~ 9 years, living with T1D ~ 22 years

6

Advancements in Diabetes Medications



7

GLP-1 Receptor Agonist Updates (2025)

- Market size growth
 - Increase from 20% to 29%
 - Semaglutide (Wegovy) growth - \$13.8 billion in sales (2025) vs \$8.1 billion (2024)
- Coverage restriction further intensified
 - Mounjaro, Ozempic, Trulicity (T2D criteria)
 - Wegovy, Zepbound
- Semaglutide
 - Ozempic approved for reducing risk of worsening kidney disease, kidney failure and cardiovascular death in adults with type 2 diabetes and CKD
 - Wegovy received accelerated approval for treatment of metabolic associated liver disease (MASH)
- Tirzepatide
 - Zepbound approved for moderate-to-severe obstructive sleep apnea (OSA) in adults with diabetes (Dec 2024)



8

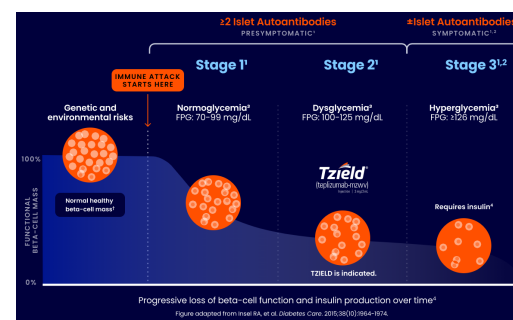
GLP-1 Receptor Agonist Pipeline

Agent	Phase	Key Feature	Estimated approval
CagriSema (Cagrilintide + Semaglutide, NovoNordisk)	Phase III	Amylin analog + GLP1 agonism, significant weight loss	2026
Orforglipron (Eli Lilly)	Phase III	Small molecule GLP1 agonism, once daily pill	2026
MariTide (maridebart, cafraglutide, Amgen)	Phase II/III	Monthly injection	2026-2027
Retatrutide (Eli Lilly)	Phase II/III	Triple agonist – GLP1/GIP/glucagon	2026-2027
Survodutide (BI), Mazdutide (Eli Lilly)	Phase II/III	GLP1/glucagon for obesity and steatohepatitis	2026-2027

9

Teplizumab (Tziel)

- First disease-modifying type 1 diabetes (T1D) therapy
- Delays stage 3 onset by 2-3 years (up to 5-7) in ages 8+ with stage 2 T1D
- Screen at risk youth via Islet autoantibody (AAb)
 - Select autoimmune disorders (Hashimoto's, Graves, Celiac)
 - Relative with T1D
 - Abnormal glucose levels
- Educate on 14-day infusion



10



Emerging Trends in Insulin Delivery

- Enhanced automated insulin delivery systems
 - Meal detection and automatic bolus
 - Moving towards more user-friendly delivery formats
 - Dual hormone close-loop system (insulin + glucagon)
- Integration of insulin delivery with AI, digital health
 - “digital twin” model
- Once weekly basal insulin
 - Icodec (Novo Nordisk)
 - Efsitora alpha (Eli Lilly)

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Insulin Icodec

- Once weekly basal insulin analogue
- Currently being studied for type 1 and type 2 diabetes
- Engineered by modifying human insulin to give a prolonged half life of approximately seven days
- ONWARDS phase III trial
 - Demonstrated glycemic control that was non-inferior or superior to once daily basal insulins
 - Insulin-naïve type 2 diabetes, icodec achieved greater reduction in HgbA1c and higher time in range compared to daily glargine with similar safety profile
- Improved adherence, treatment satisfaction
 - 365 injections/year → 52 injections/year



12



Current Pharmacotherapy

13

?

**Which diabetes drug has a
benefit in chronic kidney disease
(CKD)?**

- a) Metformin
- b) Empagliflozin (Jardiance)
- c) Semaglutide (Ozempic)
- d) Sitagliptin (Januvia)



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Diabetes Pharmacotherapy

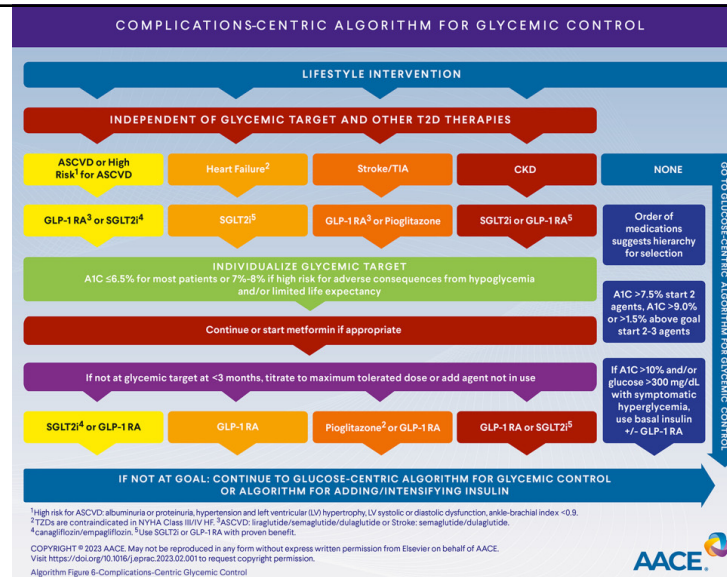
Class	Place in therapy	Pros	Cons
Metformin	First-line T2D	Inexpensive	GI side-effects (diarrhea)
GLP-1 Agonists	CVD/HF/CKD, Obesity	Weight loss, A1c lowering 1.5-5%	Cost, nausea
SGLT2 inhibitors	CKD/HF	Renal Protection	UTI risk
Sulfonylureas/Meglitinides	Second/Third-line T2D	Inexpensive	Hypoglycemia
Thiazolidinediones (TZDs)	Second/Third-line T2D	Inexpensive	CHF/edema, bladder cancer
DPP-4 inhibitors	Second/Third-line T2D	Available in combo with metformin	Expensive, low efficacy
Insulin	Advanced T2D/T1D	Flexible dosing	Hypoglycemia, weight gain

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	Biguanide	SGLT-2i	GLP-1 RA	DPP-4i	TZD	SU	Insulin
HYPOTENSION	No	No/low	No/low	No/low	No/low	Yes	Yes
WEIGHT	Neutral (potential for modest loss)	Reduction	Reduction	Neutral	Gain	Gain	Gain
ASCVD	Potential benefit	Benefit ^c	Benefit ^c ; Neutral ^a	Neutral	Potential benefit ^c	Neutral	Neutral
HF	Neutral	Benefit ^c	Neutral	Potential risk ^c	Increased risk	Neutral	Neutral
COST	Low	High	High	High	Low	Low	Low (human)/high (analog)
FORMULATION	Oral	Oral	Multiple	Oral	Oral	Oral	SQ; inhaled (human)
RENAL	Contraindicated with eGFR <30 mL/min/1.73 m²	- See labels for renal dose considerations of individual agents - Glucose-lowering effect is lower for SGLT-2i at lower eGFR	- See labels for renal dose considerations of individual agents - No dose adjustment^c - Caution when initiating or increasing dose	- Renal dose adjustment required^c; can be used in renal impairment - No dose adjustment required^c	- No dose adjustment required - Generally not recommended in renal impairment due to potential for fluid retention	- Not recommended in CKD^c - Initiate conservatively to avoid hypoglycemia^a	Lower insulin doses required with a decrease in eGFR; titrate per clinical response
ADDITIONAL CONSIDERATIONS	- GI side effects common (diarrhea, nausea) - Potential for vitamin B12 deficiency	- Discontinue before scheduled surgery to avoid potential DKA risk - DKA risk - Risk of bone fx - GI infections - Risk of volume depletion, hypotension ▲ LDL - Risk of Fournier's gangrene	- See boxed warning - GI side effects common (nausea, vomiting, diarrhea) - Injection site reactions - Discontinue if pancreatitis suspected^d	- Discontinue if pancreatitis suspected^d - Joint pain	- See boxed warning - Fluid retention (edema; heart failure) - Benefit in NASH - Risk of bone fx - Bladder cancer^e ▲ LDL^c	- See special warning ▲ CV mortality risk (older SU)^f	- Injection site reactions - Higher risk of hypoglycemia with human insulin (NPH or premix formulations) vs analogs

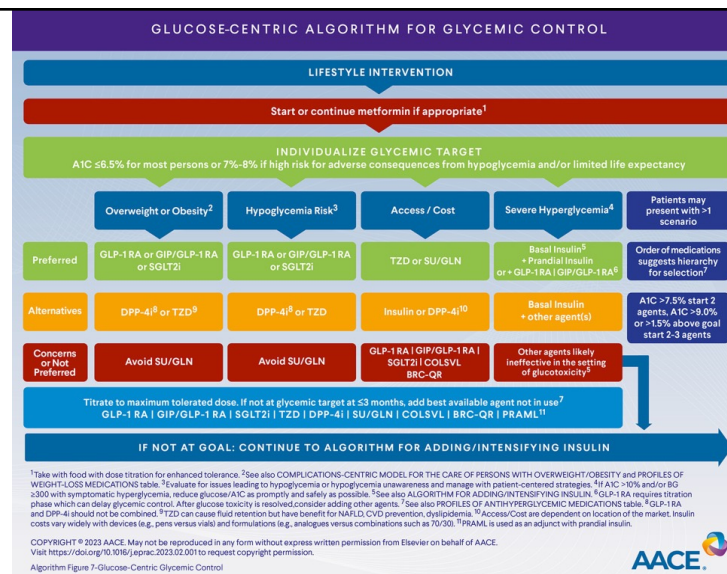
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Treatment Algorithm



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Treatment Algorithm



18



Glucagon like peptide-1 receptor agonists (GLP-1)

Trulicity (dulaglutide)	Ozempic (semaglutide)	Rybelsus (semaglutide-oral)	Victoza (liraglutide)	*Mounjaro (tirzepatide)
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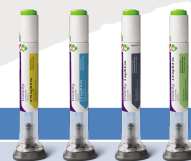
- Cardiovascular benefit, no renal dose adjustments, weight loss benefit
- Lowers blood sugar in glucose dependent fashion, slows gastric emptying/suppresses appetite
- Once weekly injection (exceptions -liraglutide daily, rybelsus oral agent daily)
- Start at lowest dose and increase dose based on tolerance and glycemic control
- Contraindications: personal or family history of thyroid carcinoma (Medullary thyroid cancer, Multiple endocrine neoplasia syndrome 2 (MEN2))
- Precautions: history of pancreatitis, gastroparesis
- Side-effects: Mostly gastrointestinal. Abdominal pain (6%- 20%), constipation (3% -24%), diarrhea (9% -30%), nausea (11% -44%), vomiting (5% -24%), fatigue, nasopharyngitis

*GLP1/GIP

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GLP-1 Receptor Dosing and Titration

Agent	Doses	Titration
Dulaglutide <i>Trulicity</i>	0.75 mg, 1.5 mg, 3 mg 4.5 mg once weekly	Initial Dosing: 0.75 mg weekly Increase to 1.5 mg/week for added glycemic control If additional glycemic control is needed, increase the dosage in 1.5 mg increments after at least 4 weeks on the current dosage Max Dosing: 4.5 mg weekly for adult; 1.5 mg weekly for pediatric patients ≥10 years
Tirzepatide <i>Mounjaro</i> <i>Zepbound</i>	2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg 15 mg once weekly	Initial Dosing: 2.5 mg weekly for 4 weeks Then, increase to 5 mg weekly May increase dose in 2.5 mg increments every 4 weeks to a max dose of 15 mg weekly



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GLP-1 Receptor Dosing and Titration

Agent	Doses	Titration
Semaglutide <i>Rybelsus</i>	3 mg, 7 mg, 14 mg	Initial Dosing: 3 mg once daily for 30 days Then, increase to 7 mg daily May increase to 14 mg daily after at least 30 days on 7 mg daily dose Administration Instructions: Take at least 30 minutes before the first food, beverage, or other oral medications of the day with no more than 4 ounces of plain water only
Semaglutide <i>Ozempic</i> <i>Wegovy</i>	0.25 mg, 0.5 mg, 1 mg, 2 mg (T2D) 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg (Weight loss, MASH)	Ozempic: Initiate with 0.25 mg weekly for 4 weeks, then increase to 0.5 mg weekly May increase to 1 mg weekly after at least 4 weeks on 0.5 mg dose May increase to 2 mg weekly after at least 4 weeks on 1 mg dose Wegovy (weight loss): Weeks 1-4: 0.25 mg weekly Weeks 5-8: 0.5 mg weekly Weeks 9-12: 1 mg weekly Weeks 13-16: 1.7 mg weekly Week 17 and on: 1.7 mg or 2.4 mg weekly Wegovy (MASH): Weeks 1-4: 0.25 mg weekly Weeks 5-8: 0.5 mg weekly Weeks 9-12: 1 mg weekly Weeks 13-16: 1.7 mg weekly Week 17 and on: 2.4 mg weekly 

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Sodium-glucose Cotransporter 2 Inhibitors (SGLT2)

Jardiance (empagliflozin)	Farxiga (dapagliflozin)	Invokana (canagliflozin)	Steglatro (ertrugliflozin)	Brenzavvy (bexagliflozin)
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- Heart failure and chronic kidney disease
- Prevents kidney from reabsorbing glucose, excretes excess glucose via urine
- Mild weight loss benefit
- Two dosing options
 - T2D: start at the lower dose and increase in 4-12 weeks if glycemic goals unmet
 - At low eGFR(<30 ml/min) efficacy limited
- Contraindications/Precautions: Euglycemia DKA, dehydration, AKI, bone fractures, hypotension/volume depletion, lower limb amputations
- Side-effects: increased urine output, UTIs, genital mycotic infections, dyslipidemia, increased thirst, nausea

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Sulfonylureas and TZDs

- Sulfonylureas
 - High efficacy, low cost
 - Glipizide, Glyburide, Glimepiride
 - Stimulates insulin secretion
 - Hypoglycemia risk
 - Avoid glyburide in elderly, CKD
 - Glipizide preferred in CKD due to shorter half-life
- Thiazolidinediones (TZDs)
 - Actos (pioglitazone)
 - Insulin sensitizer
 - Edema common side effect
 - Avoid in heart failure
 - Contraindicated in bladder cancer

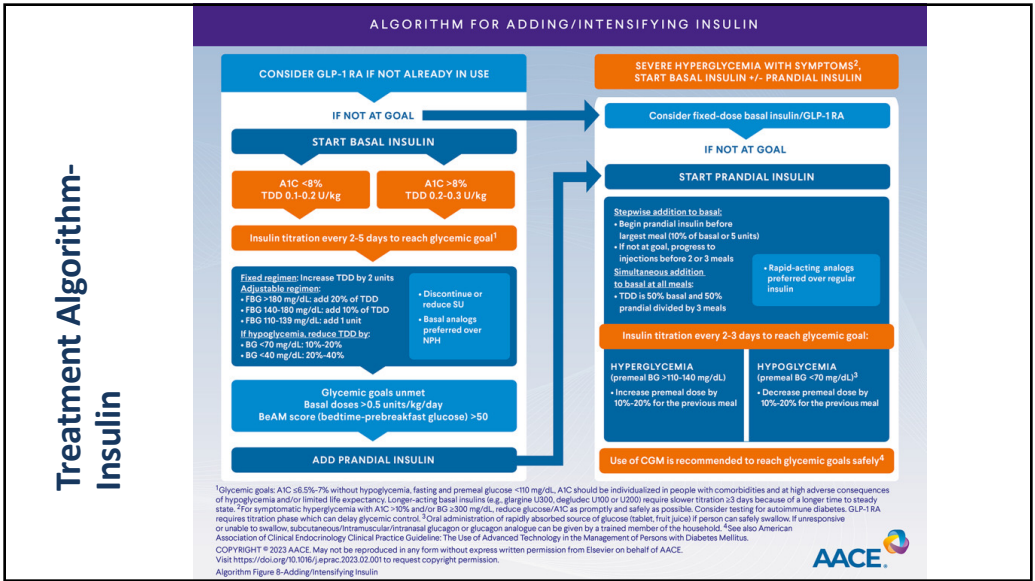
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Other Diabetes Agents

- DPP-4 Inhibitors
 - Sitagliptin (Januvia), Linagliptin (Tradjenta), Alogliptin (Nesina), Saxagliptin (Onglyza)
 - Prevents breakdown of endogenous GLP1
 - Expensive, low efficacy
 - Renal dose adjustments
 - Linagliptin does not require renal dose adjustments
- Meglitinides
 - Nateglinide (Starlix), Repaglinide (Prandin)
 - Like sulfonylureas, but longer acting
- Alpha Glucosidase Inhibitors
 - Acarbose, Miglitol
 - Prevents breakdown and absorption of complex carbohydrates
 - Bloating/cramping/flatulence
- Amylin analog
 - Pramlintide (Symlin)



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Insulin – Long Acting

Long-Acting

Basaglar [KwikPen, Tempo Pen]
Insulin glargine (analog)
Duration: 24-30 hours

Lantus [SoloStar, Vial]
Insulin glargine (analog)
Duration: 24-30 hours

Rezvoglar [KwikPen]
Insulin glargine-aglr (analog, biosimilar*)
Duration: 24-30 hours

Semglee [Pen, Vial]
Insulin glargine-yfgn (analog, biosimilar*)
Duration: 24-30 hours

Toujeo [SoloStar, Max SoloStar]
Insulin glargine (analog)
Duration: Up to 36 hours

Tresiba [FlexTouch, Vial]
Insulin degludec (analog, ultra-long)
Duration: 36-42 hours

Drug name	Dosage Form	Expiration upon opening
Basaglar (insulin glargine)	KwikPen Tempo Pen	28 days
Lantus (insulin glargine)	SoloStar Pen, Vial	28 days
Rezvoglar (insulin glargine-aglr)	KwikPen	28 days
Semglee (insulin glargine-yfgn)	Pen, Vial	28 days
Toujeo (u-300) (insulin glargine)	SoloStar, Max Solostar u-300	56 days
Tresiba (u-100, u-200) (insulin degludec)	FlexTouch, Vial	56 days

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Insulin – Combination Products

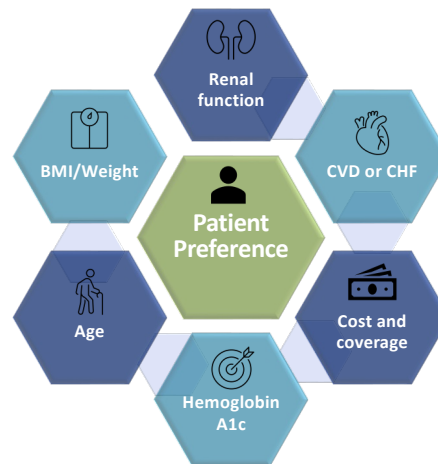
Intermediate + Rapid-Acting		Intermediate + Rapid Acting		
		Drug name	Dosage Form	Expiration upon opening
 Humalog Mix 50/50 [KwikPen] Insulin lispro protamine (50%)/lispro (50%) (analog) Duration: Up to 24 hours	 Humalog Mix 75/25 [KwikPen, Vial] Insulin lispro protamine (75%)/lispro (25%) (analog) Duration: Up to 24 hours	 NovoLog Mix 70/30 [FlexPen, Vial] Insulin aspart protamine (70%)/aspart (30%) (analog) Duration: Up to 24 hours		
		Humalog Mix 50/50 Insulin lispro protamine (50%)/lispro (50%)	KwikPen	10 days
		Humalog Mix 75/25 Insulin lispro protamine (75%)/lispro (25%)	KwikPen, Vial	10 days, 28 days
Intermediate + Short-Acting		Intermediate + Short Acting		
		Drug name	Dosage Form	Expiration upon opening
 Humulin 70/30 [KwikPen, Vial] Insulin isophane (70%)/regular insulin (30%) (human) Duration: Up to 24 hours	 Novolin 70/30 [FlexPen, Vial] Insulin isophane (70%)/regular insulin (30%) (human) Duration: Up to 24 hours			
		Humulin 70/30 Insulin isophane (70%)/Regular insulin (30%)	KwikPen, Vial	10 days, 31 days
		Novolin 70/30 Insulin isophane (70%)/Regular insulin (30%)	FlexPen, Vial	28 days, 42 days

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Application and Clinical Pearls

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Patient Specific Factors to Determine Therapy



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Common Barriers to First-line Options

Medication	Problem
Metformin	Diarrhea, GI side effects Misconceptions (causes cancer) Renal impairment
SGLT-2 Inhibitors	Cost UTI or yeast infections Urinary incontinence
GLP-1 Agonists	Cost Fear of injection Underweight/excessive weight loss GI side-effects (nausea, vomiting)
Insulin	Fear of injection(s) Sense of failure Weight gain Hypoglycemia risk/fear Misconceptions (causes kidney damage, loss of independence)



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Common Barriers to First-line Options - Strategies



Metformin	Diarrhea, GI side effects Misconceptions (causes cancer) Renal impairment	Lower dose, extended-release form, take with food Get to the root of the fear, educate, revisit Lower dose, monitor, discontinue when eGFR <30
SGLT-2 Inhibitors	Cost UTI or yeast infections Urinary incontinence	Explore access Counsel on good hygiene (wipes, water) Fluconazole Weigh risk vs. benefit
GLP-1 Agonists	Cost Fear of injection Underweight/excessive weight loss GI side-effects (nausea, vomiting)	Explore access Use demos, first injection in clinic Work with RD Small meals, avoidance of trigger foods, slow titration
Insulin	Fear of injection(s) Sense of failure Weight gain Hypoglycemia risk/fear Misconceptions (causes kidney damage, loss of independence)	Practice with demos Change mindset towards insulin "gift" vs. "curse" Nutrition/Exercise plan CGM, prevention & appropriate treatment Dismantle inaccurate beliefs

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Patient Case – MZ

- 68yo female, T2D (A1C 9.2%), eGFR 35 mL/min (stage 3 CKD), prior metformin GI intolerance, having hypoglycemic episodes
- PMH: T2D, Hypertension, CKD, Osteoarthritis, history of Myocardial Infarction (MI)
- Sporadic eating habits. "Sweet tooth"
- Checking glucose once daily in the morning before breakfast – 140s-180s
- Fearful of low blood sugars, dislikes taking medications, hesitant about injections. Doesn't want to end up on insulin
- Weight: 225lbs BMI: 38
- Medicare insurance

Current Medications

Jardiance 25 mg daily
Glimepiride 1 mg daily
Aspirin 81 mg daily
Atorvastatin 80 mg daily
Losartan 50 mg daily
Metoprolol 25 mg BID

What medications changes should we make to reach glycemic goals?

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Patient Case – MZ

- 68yo female, T2D (A1C 9.2%), eGFR **35 mL/min** (stage 3 CKD), prior metformin GI intolerance, having **hypoglycemic** episodes
- PMH: T2D, Hypertension, **CKD**, Osteoarthritis, history of Myocardial Infarction (MI)
- **Sporadic eating habits**. “Sweet tooth”
- Checking glucose once daily in the morning before breakfast – 140s-180s
- Fearful of low blood sugars, dislikes taking medications, hesitant about injections. Doesn’t want to end up on insulin
- Weight: **225lbs** BMI: **38**
- Medicare insurance

Current Medications

Jardiance 25 mg daily
Glimepiride 1 mg daily
 Aspirin 81 mg daily
 Atorvastatin 80 mg daily
 Losartan 50 mg daily
 Metoprolol 25 mg BID

Discontinue sulfonylurea (glimepiride) due to hypoglycemia, CKD

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Patient Case – MZ

- 68yo female, T2D (A1C 9.2%), eGFR 35 mL/min (stage 3 CKD), prior metformin GI intolerance, having hypoglycemic episodes
- PMH: T2D, Hypertension, **CKD**, Osteoarthritis, history of **Myocardial Infarction (MI)**
- Sporadic eating habits. **“Sweet tooth”**
- Checking glucose once daily in the morning before breakfast – 140s-180s
- Fearful of low blood sugars, dislikes taking medications, **hesitant about injections**. **Doesn’t want to end up on insulin**
- Weight: **225lbs** BMI: **38**
- Medicare insurance

Current Medications

Jardiance 25 mg daily
~~Glimepiride 1 mg daily~~
 Aspirin 81 mg daily
 Atorvastatin 80 mg daily
 Losartan 50 mg daily
 Metoprolol 25 mg BID
Semaglutide 0.25 mg once weekly for weeks 1-4, 0.5 mg once weekly thereafter

Add GLP-1 agent. Assuage concerns towards injection therapy. Refer to RD for diet education/MNT. Ensure affordability

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Ongoing care & follow-up

- Telehealth
- Assess medication tolerance & adherence
- Multidisciplinary approach
 - Clinical pharmacist medication adjustments
 - Nurse-led education
 - RD nutrition plans



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Patient Case- AF

- 66yo male with type 2 diabetes, hypertension, and hyperlipidemia
- Last A1c 8.5%
- Takes Metformin 1000 mg twice daily and Glipizide 5 mg twice daily with meals
- Current weight 290 lbs, would like to lose weight
- Medicare insurance with fixed income



Prescribed Ozempic (semaglutide) but tells you his copay is over \$400 and he cannot afford this!

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Navigating Cost Barriers

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POLL

On a scale of 1-5, How confident are you with navigating insulin cost barriers?

- a) Zero confidence
- b) I know a little
- c) Somewhat, I usually ask
- d) I know most of the barriers and how to get around them
- e) Pretty much a pro!



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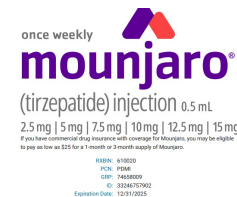
Common Cost Barriers with Diabetes Medications

- GLP1 agonists
 - >\$1000/month
 - High-deductible insurance plans → copay unaffordable
 - Prior authorization coverage delays
- SGLT2 inhibitors
 - \$500-\$600/month
 - High-deductible insurance plans → copay unaffordable
- Insulin
 - High copay for monthly supply
 - “Refill too soon”
 - Lapse in insurance
 - Insurance formulary preference rejections/coverage delays

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Strategies to Overcome Cost Barriers – GLP1 Agonists

- Determine or verify cause
- Non-formulary
 - Switch to covered GLP1 agent
 - KY Medicaid: Ozempic
 - OH Medicaid: Trulicity
- High copay with high-deductible plan
 - Medicare: refer to patient assistance program, extra help, prescription payment plan (M3P), patient access network (PAN) foundation
 - **Commercial:** copay savings card
- Local charitable pharmacy



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Strategies to Overcome Cost Barriers – SGLT2 inhibitors

- Determine or verify cause
- Non-formulary
 - Switch to covered agent
- High copay with high-deductible plan
 - Medicare: refer to patient assistance program, extra help, prescription payment plan (M3P), patient access network (PAN) foundation
 - **Commercial:** copay savings card
- Cost-Plus Drugs
 - Brenzavvy (bexagliflozin)
- Local charitable pharmacy



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Medicare Prescription Payment Plan (M3P)

- Helps Medicare beneficiaries manage prescription costs by spreading out-of-pocket drug costs over the year
- Useful for high-cost medications like GLP-1 agonists, SGLT2s
- Voluntary program
 - Enroll or opt out at any time
- No up-front cost to pick up medication at pharmacy
- Monthly bills for the cost of the drug
- Does not lower cost of the drug, but allows for payments to be spread out
- Medicare enrollees will pay no more than \$2000 for covered medications in a plan year, whether they opt in or not

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Manufacturer Patient Assistance Programs (GLP1, SGLT2i)

NeedyMeds.org
Rxassist.org

	Program	Income criteria
Ozempic (semaglutide)	Program discontinuing 2025	n/a
*Trulicity (dulaglutide)	Lilly Cares	300% Federal Poverty Limit or less
Mounjaro (tirzepatide)	n/a	n/a
Jardiance (empagliflozin)	BI Cares	250% Federal Poverty Limit or less
Farxiga (dapagliflozin)	AZ&Me	300% Federal Poverty Limit or less
<i>*plus additional criteria – on GLP1, failed metformin, requires combination therapy and A1c 7.5% or greater, established CVD or multiple CV risk factors</i>		

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Strategies to Overcome Cost Barriers – Insulin

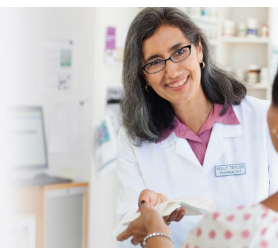
- Non-formulary
 - Switch to preferred agent
- Lilly Insulin Value Program
 - [Insulinaffordability.lilly.com](https://insulinaffordability.lilly.com)
 - All Lilly insulins available for \$35
 - Ex: Basaglar, Humalog, Lyumjev
- NovoCare MyInsulinRx
 - [Novocare.com/helpwithcosts](https://novocare.com/helpwithcosts)
 - All Novo insulins available for \$35
 - Ex: Novolog, Fiasp, Tresiba
- Emergency Supply Voucher
- Patient Assistance Programs
 - Novo Nordisk, Sanofi, Lilly Cares

Immediate Supply

If you are at risk of rationing your insulin and have an immediate need, we may be able to help with a one-time offer for a free, short-term supply of Novo Nordisk insulin.* Sign up for this offer below and use it within 30 days or it will expire.

It's critical that you find a long-term solution for affording your insulin. Find help with insulin costs [here](#) or call us at 1-844-Novo4Me (1-844-668-6463) to learn how we can help.

*See terms and conditions for details.



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Patient Cases – Cost Barriers

- 66yo male with type 2 diabetes, hypertension, and hyperlipidemia
- Last A1c 8.5%
- Takes Metformin 1000 mg twice daily and Glipizide 5 mg twice daily with meals
- Current weight 290 lbs, would like to lose weight
- Medicare insurance with fixed income



- Has \$590 deductible for plan year
- Contacts plan to enroll in M3P, able to spread out Ozempic payments to \$50/month

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Strategies for Accessing Medications Without Insurance

- Pursue long-term solution
 - Apply for Medicaid
 - Healthcare.gov
- Leverage health care system discounts/programs
- Switch to generics or low-cost alternative
 - Use GoodRx, pharmacy discount programs
- Connect with charitable pharmacy
- Pursue/apply for patient assistance programs or patient assistance network for high-cost drugs
- Drug vouchers or office samples for immediate needs



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